MUST DOs
(Refer to relevant guideline)

Upper respiratory tract symptoms and/or fever WITHOUT shortness of breath or hypoxia

Additional in moderate or severe disease at high risk of progression
Consider Remdesivir for up to 5 days (200 mg IV on day 1 followed by 100 mg IV OD for next 4 days)
- To be started within 10 days of onset of symptoms, in those having moderate to severe disease with high risk of progression (requiring supplemental oxygen), but who are NOT on IMV or ECMO.
- No evidence of benefit for treatment more than 5 days
- NOT to be used in patients who are NOT on oxygen support or in home setting
- Monitor for RFT and LFT (remdesivir not recommended if eGFR <30 ml/min/m2; AST/ALT >5 times UNL) (not an absolute contraindication)

Additionally in rapidly progressing moderate or severe disease
Consider Tocilizumab preferably within 24-48 hours of onset of severe disease/ ICU admission [4 to 6 mg/kg (400 mg in 60 kg adult)] in 100 ml NS over 1 hour if the following conditions are met:
- Rapidly progressing COVID-19 not responding adequately to steroids and needing oxygen supplementation or IMV
- Preferably to be given with steroids
- Significantly raised inflammatory markers (CRP and/or IL-6)
- Rule out active TB, fungal, systemic bacterial infection
- Long term follow up for secondary infections (such as reactivation of TB, flaring of Herpes)

Home Isolation & Care

Mild disease
- Upper respiratory tract symptoms and/or fever WITHOUT shortness of breath or hypoxia

Moderate disease
- Any one of:
  1. Respiratory rate ≥ 24/min, breathlessness
  2. SpO₂ ≤ 93% on room air

Severe disease
- Any one of:
  1. Respiratory rate >30/min, breathlessness
  2. SpO₂ < 90% on room air

ADMIT IN WARD

Oxygen Support:
- Target SpO₂: 94-96% (88-92% in patients with COPD)
- Preferred devices for oxygenation: non-rebreathing face mask
- Awake proning encouraged in all patients requiring supplemental oxygen therapy (sequential position changes every 2 hours)

Anti-inflammatory or immunomodulatory therapy:
- Dexamethasone 6 mg/day or equivalent dose of methylprednisolone (32 mg in 4 divided doses) usually for 5 to 10 days or until discharge, whichever is earlier.
- Patients may be initiated or switched to oral route if stable and/or improving
- There is no evidence for benefit for systemic steroids in those NOT requiring oxygen supplementation, or on continuation after discharge
- Anti-inflammatory or immunomodulatory therapy (such as steroids) can have risk of secondary infection such as invasive mucormycosis when used at higher dose or for longer than required

ADMIT IN HDU/ICU

Respiratory & Cardiovascular Support:
- Consider use of NIV (Helmet or face mask interface depending on availability) in patients with increasing oxygen requirement, if work of breathing is LOW
- Consider use of HFNC in patients with increasing oxygen requirement
- Intubation should be prioritized in patients with high work of breathing / if NIV is not tolerated
- Use institutional protocol for ventilatory management when required

Anti-inflammatory or immunomodulatory therapy:
- Dexamethasone 6 mg/day or equivalent dose of methylprednisolone (32 mg in 4 divided doses) usually for 5 to 10 days or until discharge, whichever is earlier. No evidence for benefit in higher doses.
- Anti-inflammatory or immunomodulatory therapy (such as steroids) can have risk of secondary infection such as invasive mucormycosis when used at higher dose or for longer than required

Anticoagulation:
- Prophylactic dose of unfractionated heparin or Low Molecular Weight Heparin (weight based e.g., enoxaparin 0.5mg/kg per day SC). There should be no contraindication to high risk of bleeding
- Maintain euvolemic hemodynamic instability, Change in oxygen requirement
- Serial CXR; HRCT chest to be done ONLY if there is worsening
- Lab monitoring: CRP, D-dimer, blood sugar 48 to 72 hrly; CBC, KFT, LFT 24 to 48 hrly

Supportive measures:
- Clinical Monitoring: Work of breathing.

DO NOT USE IN COVID-19
- Lopinavir-ritonavir
- Hydroxychloroquine
- Ivermectin
- Neutralizing monoclonal antibody
- Convolvulaceae plasma
- Molnupiravir
- Favipiravir
- Azithromycin
- Doxycline

*High-risk for severe disease or mortality
- Age > 60 years
- Cardiovascular disease and CAD
- Diabetes mellitus and other immunocompromised states (such as HIV)
- Active tuberculosis
- Chronic lung/kidney/liver disease
- Cerebrovascular disease
- Obesity
- Unvaccinated

**Antibiotics should not be used unless there is clinical suspicion of bacterial infection
Possibility of coinfection of COVID-19 with other endemic infections must be considered
Systemic corticosteroids are not indicated in mild disease

High work of breathing /risk of progressing severe disease
- Intubation should be prioritized
- Use institutional protocol for ventilatory management when required
- Monitor for RFT and LFT (remdesivir not recommended if eGFR <30 ml/min/m2; AST/ALT >5 times UNL) (not an absolute contraindication)

After clinical improvement, discharge as per revised discharge criteria